EXHIBIT 13

105TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPORT
105–149

BALANCED BUDGET ACT OF 1997

REPORT

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 2015

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SUBSECTIONS (b)(1) AND (c) OF SECTION 105 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1998

together with

ADDITIONAL AND MINORITY VIEWS

JUNE 24, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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provision is intended to promote efficiency, increase uniformity, and reduce administrative burdens in claims administration and billing procedures.

Effective Date. The provision is effective upon enactment.

Section 10615. Updates for ambulatory surgical services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI–U. OBRA 93 eliminated updates for ASCs for FY1994 and FY1995.

Explanation of Provision. The provision would set the updates for FY 1998 through FY2002 at the increase in the CPI–U minus 2.0 percentage points.

Reason for change. This provision would contribute to slowing unsustainable growth in Part B expenditures.

Effective date. This provision is effective for services delivered on or after October 1, 1997.

Section 10616. Reimbursement for drugs and biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment shall be equal to 95 percent of the average wholesale price for the drug or biological involved.

Reason for Change. The Inspector General for the Department of Health and Human Services has found evidence that over the past several years Medicare has paid significantly more for drugs and biologicals than physicians and pharmacists pay to acquire such pharmaceuticals. For example, the Office of Inspector General reports that Medicare reimbursement for the top 10 oncology drugs ranges from 20 percent to nearly 1000 percent per dosage more than acquisition costs. The Committee intends that the Secretary, in determining the average wholesale price, should take into consideration commercially available information including such information as may be published or reported in various commercial reporting services. The Committee will monitor AWPs to ensure that this provision does not simply result in a 5% increase in AWPs.

Effective Date. The provision is effective January 1, 1998.

Section 10617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for a self-administered oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before,

during or after the administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

The provision would establish a per dose payment limit equal to 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of or payment for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

Reason for Change. In certain cases, HCFA does not provide coverage for pharmaceuticals approved for coverage by the Food and Drug Administration, even when such pharmaceuticals meet criteria necessary for coverage under current law.

Effective Date. The provision is effective January 1, 1998.

Section 10618. Rural health clinics (RHCs)

Current Law. Medicare establishes payment limits for RHC services provided by independent (RHCs). RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous nine years. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professional shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professional shortage area , the Secretary would be required to continue to consider the facility to meet the health professions shortage area requirement.

Explanation of Provision. The provision would apply per-visit payment limits to all RHCs, other than such clinics in rural hospitals with less than 50 beds. The provision would require that RHCs have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review. The provision would amend the waiver on the staffing requirement, to provide a waiver if the facility can not meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50% of the time the clinic operates; such a waiver is only available to clinics once they have been certified. The provision would require that shortage designations for RHCs be reviewed every three years. The provision would further amend the shortage area requirement by adding that RHCs must be located in areas in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. The provision would require that operating RHCs that subsequently fail to meet the requirement of being located in a health professional shortage area, continue to be considered to meet the health professional shortage requirement, but only when, under criteria established by the Secretary in regulations, the RHCs are determined to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served